GENERAL PRACTITIONERS AT THE DEEP END
INTERNATIONAL BULLETIN NO 12
NOVEMBER 2024

We begin this Bulletin with a big welcome to two new Deep End Projects, based on Emergency Medicine in Scotland (Page 11) and the Deep End Living Lab in Frankston, Australia (Page 13) - the 19th and 20th Deep End Projects, in a network now spanning 9 countries in 4 continents.

In an update to Bulletin No 11, which featured the Deep End International Conference in Glasgow last April, it's a pleasure to flag the brilliant 9 minute video of the conference (https://www.youtube.com/watch?v=NRqjRPQkNvE) produced and generously donated by Ed Sharp-Paul.

It was pointed out that while there was a workshop at the conference addressing the issue of climate change, neither the video nor the plenary presentations addressed this subject, raising the question of whether it is a priority for Deep End Projects.

On Page 4 Tim Senior from Australia, Noy Basu from Glasgow and Liliana Risi from London have written a short article on Climate Creation in the Deep End. In preparation for Deep End International Bulletin No 12, their article was pre-circulated for comment, which produced a range of replies, which may be characterised as representing either Deep End Projects recognising climate change as important but external to their main concerns, or Deep End Projects which see Climate Change as integral to Health Equity and therefore part of the business of a Deep End Project.

Examples of the latter approach in East of England, Bristol and Glasgow are described on Pages 6, 7 and 8.

Tim Senior and Graham Watt in Glasgow, August 2024

Tim Senior was a welcome visitor to the UK and Ireland during the summer and writes about his experience on Page 17 including links to separate reports of his visit to the Society of Academic Primary Care Conference at Bristol, plus visits to Deep End Projects in Plymouth, Dublin, Sheffield, London and Glasgow.

On Page 15, Tom Ratcliffe of Fairhealth, following a successful workshop at the Glasgow conference, invites participation in a series of poetry writing workshops. To illustrate the potential of poetry to highlight issues in health and health care, the Bulletin includes 5 poems by Nuala Watt, a poet and disability activist, whose recently published book *The Department of Work and Pensions Assesses a Jade Fish*, has been shortlisted for the Saltire Society First Book Award (Page 43)

Finally, there are annual reports from 10 Deep End Projects in 7 countries – new and old, big and small, national and local – brilliantly inspiring as always.

Graham Watt graham.watt@glasgow.ac.uk November 2024

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CLIMATE HEALTH CREATION IN THE DEEP END

Tim Senior, Noy Basu and Liliana Risi

"We are all in the gutter but some of us are looking at the stars"

Oscar Wilde

How does nature regenerate and give us joy in the Deep End?

I ask this having just travelled from Australia to visit Deep End GPs in the UK and Ireland and in conversations with Noy and Liliana.

I saw challenges that will be familiar to all of us. Everyone's workload is enormous, we're constantly managing multiple complex demands, and the system we work in is unsupportive, even antagonistic. However, I saw people who were still finding spaces for joy in their work, and frequently these were related to the people and the nature around them.

Why is this important?

Because not only do we all have a responsibility for global health, but increasingly evidence shows that our communities and nature are the medicine we all need. As I've travelled, I've seen Deep End GPs acting on climate change, because it creates joy for them and the people around them. And when done right, can ease future workload.

I've spoken with Dr Charlotte Brayson in Sheffield, who proudly showed me the garden she created during the COVID-19 lockdowns. I visited Dr Tamsin Ellis, one of the Directors of Greener Practice (1) who just through taking small steps in making improvements, now takes joy in being a centre for recycling medication blister packs and being a practice which shares plant cuttings and hosts local musicians in their waiting room.

I saw GPs celebrate those small wins we get with patients: the person who manages to walk more and drive less; the family who can eat less processed food by using a food co-op with an affordable range of healthy food. These may not be explicitly for climate reasons, but the impact is no less for this.

In Sheffield I was a guest at their Community in the Kitchen event, where GPs got together over a delicious, inclusive vegetarian meal which provided nourishment, camaraderie, and support. As it happens, there's a positive environmental and

financially sustainable (2) impact from the lack of meat, positive health impacts, and increased equity as all cultures and beliefs can join without being singled out.

And there was joy in the room!

We know that the same things that promote personal health and community health are the same things that promote planetary health, the so-called co-benefits. We're already acting on climate because we're acting on health equity. We're already listening to the needs of our patients and working with them to co-create wellbeing. We're already protecting the health of our most vulnerable communities in heatwaves and droughts. We're already advocating for them individually, in environments that keep them unwell, such as housing that doesn't stand up to the extremes of climate.

We're already advocating at a policy level against policies that exclude or harm our patients and equipping future doctors for the challenges ahead through a curriculum that is congruent with a fairer greener world.(3)

And we're already quietly subverting systems to mitigate the worst of the harms that disproportionately affect our patients and harness the significant potential of social prescribing in our wild and green spaces. Because green prescribing has already shown millions of pounds of NHS savings for the NHS when we invest in a Natural Health Service (4)

It's clear that acting on climate change is a crucial part of our work as Deep End GPs (5), and it may seem overwhelmingly because our workload is unmanageable. But we are already doing this work anyway. Even when it's not explicitly about climate change it has a climate impact.

Many of the things we can be doing to act on climate change also reconnect us to our communities and each other through connecting with nature.

This, then, is not a request to do yet more stuff.

It's an invitation to pause, look up at the stars and create more joy in our work.

Tim Senior, GP working in Aboriginal and Torres Strait Islander Health in Australia.
Nayanika / Noy Basu, Sessional GP and University lecturer in Glasgow, Scotland
Liliana Risi, Non- Executive Director Greener Practice, London

References

1. Greener Practice https://www.greenerpractice.co.uk
2. Could plant based diets transform health care spending? https://www.ohe.org/insight/could-plant-based-diets-transform-health-care-spending/
3. Population and Planetary Health https://www.rcgp.org.uk/mrcgp-exams/gp-curriculum/professional-topic-guides#population
4. The Wild Life Trusts Natural Health Service: Saving lives and saving money https://www.wildlifetrusts.org/sites/default/files/2023-07/23JUN_Health_Report_Summary_FINAL.pdf
5. Climate Change and Health Inequalities Deep End Report 38 (2021) https://www.gla.ac.uk/media/Media_819283_smxx.pdf

RESPONSES TO THE ABOVE ARTICLE

When this article was circulated for comment to every Deep End Project, there was a range of responses. Below are three of the most positive and active responses, setting trails that others might follow.

Response from the East of England

Climate change & Environmental sustainability is the additional workstream that Deep End: EoE identified was missing from our Deep End predecessors – we copied the WEAR acronym – but adapted it to A-CREW (Advocacy, Climate change & Environmental sustainability, Research, Education, Workforce & Wellbeing)

In our short video for the Deep End conference we highlighted that we felt all Deep End networks should include 'C' too, so it is great to hear of its inclusion.

If you have not already included a link to The Lancet Countdown on health and climate change I would certainly recommend this.

Jessica Randall Carrick

Response from Bristol

GPs at the Deep End Bristol recognises the climate emergency and the fact that our most vulnerable community members are being hit first and worst. We are working with local communities to empower them to take actions which simultaneously improve health and tackle the climate crisis. Check out our Climate Action page for further details.

Beth Winn

GREENER PRACTICE

You know there's a problem

You want to do something

But how?

This leaflet will get you started

Planetary Health – How to start taking action

Climate change is the greatest global health threat facing the world in the 21st century[1]. We need to act but sometimes it can feel difficult to know where to begin. The BBC documentary, Climate Change: The Facts, provides an excellent overview and sets out some easy key things we can all do.

Don't get over whelmed. You don't have to do it all. Our lives are busy enough already. Start small and go from there. We don't need a few people tackling this perfectly; we need all of us doing it imperfectly together. This leaflet outlines some achievable actions in our professional and personal lives which can make a difference.

Professional Life

Day to day

Prescribe prudently. Prescribing accounts for >65% of the carbon footprint of primary care[2]. Careful prescribing, instigating regular medication reviews + advising about safe medication disposal can all have a big impact.

Prescribe greener inhalers. Meter-dose inhalers account for ~4% of the entire NHS carbon footprint yet effective alternatives are available[2].

Encourage active travel e.g. walking + cycling to patients and staff.

Promote medication alternatives e.g. nature-based interventions and social prescriptions which have been shown to improve well-being + depression[3-4].

Green Team

- Sign your GP practice up to the Green Impact for Health Toolkit + use it to help the practice become more eco-friendly
- Set up a Green Team at work + do the toolkit together
- Switch your practice to a Green Energy supplier

Wider influence

- Talk to everyone you can about Planetary Health and its importance for human health. This 4 min video has tips for how to have conversations about climate change whilst this article discusses talking to patients.
- Set up a local Greener Practice group if one doesn't already exist
- Join Green Health Action groups like Greener Practice, Health Declares, MedAct + Doctors for XR
- Learn more about the issues e.g. Introduction to net zero; Sustainable Primary Care

1. Lancet Countdown report 2020
2. Sustainable + environmentally friendly general practice: GPC England policy document – June 2020
3. Robinson J & Breed M 2019, 'Green Prescriptions + their co-benefits: Integrative strategies for public + environmental health', *Challenges 10(1)*
4. Husk K et al 2019, 'Social prescribing: where is the evidence?' BJGP 69 (678): 6-7

Response from Scotland

The priority areas of focus in NHS Greater Glasgow and Clyde (NHSGGC) have been on de-prescribing , realitic medicine, respiratory care, waste management and greener travel.

We have undertaken a QI project in improving respiratory care, with 22 early adopter practices. This has shown, compared to baseline and the rest of NHSGGC, a big reduction in ordering of 6+ SABA inhalers per year (clinical safety improvement), a shift from MDIs to DPIs (climate impact improvement) and, despite concerns about higher DPI costs, a prescribing cost showing neutral/slight benefit.

There has also been anecdotal improved job satisfaction among the practice nurses leading the projects in their practices at being able to make a difference. The project has shown the importance of holistic respiratory QI rather than a simplistic switching from MDI to DPI inhalers. Its success has been dependent on a health improvement lead with a remit for primary care who has developed a straightfoward QI audit tool for practice nurses.

Reelevant Scottish Deep End Reports include :-

Deep End Report 38 climate change (gla.ac.uk)
Deep End Report 40 - What can general practice do to mitigate the effects of cost of living crisis (gla.ac.uk) – which includes, at the end of the report, a template for lobbying MSPs on the impact of cold damp housing on health.

A small group of Glasgow-based GPs and NHS Officers working in sustainability, community wealth building and primary care were invited to an online evening round table discussion to reimagine the place of General Practice and Primary Care in the community. The discussion drew on the linked perspectives of anchor institutions, community wealth building, sustainable health care practice and a just transition to net zero to frame a reappraisal of the role of GP practices and primary care teams within their local populations.

Participants were asked to read two key papers in preparation for the Discussion. The starting premise was that the twin crises of health inequality and climate emergency are inextricably linked by common causes and by common solutions, which require a radical rethink of our role as general medical practitioners. The workshop provided space to step back with colleagues and imagine what that our role might be and to envisage practical steps that can be taken now towards the GP practice of the future.

The conversation reported here is offered as a contribution to the collective task of imagining our way as primary health care providers into a sustainable, equitable Scotland. We hope that it provides a stimulus to practical steps towards a future we desire and in which we will all thrive and flourish. Of the many actions identified by the group, immediate priorities were highlighted:

Five steps for the NHS in Scotland to take right now:

1. **Set up a Green NHS Futures Fund**, **or equivalent, to improve patient care, reduce inequalities, and deliver transformation towards a net zero carbon future.** For GP practices this might support measures such as completing the Greener Practice award, using the Zero Waste Scotland business support service or other measures to reduce carbon footprint, taking part in employability schemes to open access to work in primary care, switching to local procurement suppliers, and much more.

2. **Set up a national programme to change, when possible, metered dose respiratory inhaler prescriptions (MDIs) to low greenhouse emissions inhalers and to recycle all inhalers after use.** Metered dose inhalers contain propellants which are very potent greenhouse gases and account for 13% of the carbon footprint of General Practice. Alternative types of inhaler have a far lower carbon footprint and are as effective. Switching needs to be tailored to individuals, however, evidence from other countries suggests that over 80% of people with asthma/COPD do not need to use MDIs and could use safer types of inhalers.

3. **Integrate energy saving and fuel poverty advice, as well as welfare advice and housing support, into every GP practice and primary care team, to help individuals reduce energy wastage and mitigate the cost of living crisis.** This could be as embedded workers or through up-skilling existing primary care team roles to provide this service.

4. **Provide free travel by public transport to all health care appointments, with appointment letters or an NHS travel app accepted as travel passes.** This would be supported by active travel plans being created for every GP practice, primary and social care hub, hospital and specialist clinic in the country.

5. Introduce electronic prescribing urgently to bring NHS Scotland into line with the rest of the UK, save health care professional time, improve patient safety, reduce paper usage and carbon emissions and save patient time and travel.

Peter Cawston

T

H E

E Y E

C H A R T

I scowl towards his voice. He says the map
marks how far vision goes. If I could creep

up close I'd learn the journey. His technique
restricts me to a chair so he can track

how far I travel down the chart alone
before I pause. I grope in the third line –

my limit the next shape I recognize –
then stop. No way. I still believe my eyes

can hold a solar system, catch all lights,
deliver to the doctor alphabets

as small as atoms. But this world is smudge.
I'm huddled at the bottom of the page,

trying to hide my dark. Wherever I am,
I've bypassed every symbol I can name

and stumble at my vision's borders
where letters are illegible as stars.

Nuala Watt

This poem was included in *Tools of the Trade*, an anthology of 5O poems and poets, which is sent to all new medical graduates in Scotland, now in its 4th Edition.

NEW DEEP END PROJECTS

EMERGENCY MEDICINE AT THE DEEP END

With the support and encouragement of the Scottish Deep End Project, 2024 saw the launch of Emergency Medicine at the Deep End. We are a group of Emergency Medicine clinicians recognising that Emergency Departments face the same challenges as General Practice in mitigating the social determinants of health at the Deep End.

From a small group of interested clinicians meeting in a Glasgow tenement kitchen, we have now hosted three wider meetings of interested parties from across the UK, online and in-person at the University of Glasgow. Taking cues from the Scottish Deep End Project roundtable discussions, our themes so far have focussed on defining the challenge, and reducing the harms of violence. We have been fortunate to have had engagement and support from a range of partner organisations like Medics Against Violence and Redthread who presented their important work providing social support from the Emergency Department.

The group is structured around four key aims: support for meaningful intervention; advocacy; research; and education on the social determinants of health in emergency care. The group published a position paper, “At the Deep End: towards a social emergency medicine”, in the Emergency Medical Journal highlighting the social patterning of Emergency Department attendance, the impact of socioeconomic deprivation on patient experience, and the poorer outcomes faced by vulnerable patient groups in emergency care [1].

Research outputs from within the group have identified the potential benefits of targeted social support from within the Emergency Department. These ideas have been presented at the recent Royal College of Emergency Medicine Annual Scientific Conference and to the college patron HRH Princess Anne. The Sunday Post in Scotland also published an article on the establishment of the group and Deep End issues in emergency care. This brought some much welcome coverage of the advocacy aims of the group.

Some members were fortunate to attend the Deep End conference in Glasgow in April. It was an excellent opportunity to share the successes and challenges of establishing a Deep End group, as well as to reflect on the shared experience of this work across borders and medical specialities. We have enormously benefitted from the example of the Scottish Deep End Project and similar projects around the world. We look forward to continuing close collaboration as our own group grows and develops. As with any new group, our focus now is to ensure continued momentum and sustainability. Over the next year we hope to expand our reach across the UK and beyond, while looking closer to home to understand how funding for the group might allow us to deliver our aims more effectively.

Our next meeting is planned for 7th February 2025, and we welcome attendees from across healthcare and beyond. If you would like to join us, please to get in touch at deependem@gmail.com, through our website at www.ematthedeepend.com, or through Twitter/X @ematthedeepend

A photo from the first meeting of Emergency Medicine at the Deep End, hosted by the Scottish Deep End Project.

DEEP END LIVING LAB FRANKSTON, AUSTRALIA

We are pleased to announce the formation of a Primary Health Care at the Deep End in the Frankston and Mornington Peninsula region of Melbourne, Australia. We are grateful to be able to learn from the global Deep End movement's incredible research, education, advocacy, community engagement efforts over the years. Our aim is to adapt these lessons to the Australian context and add to the Deep End movement's efforts to overcome health inequities all over the world.

Australia's health system delivers essential health services to 26 million people across a vast geographic area over 8 states and territories. Australia has a universal health care scheme (Medicare) that funds primary care, plus a network of public hospitals that together are designed to provide free or low-cost health services to all Australians. However, significant inequities persist, particularly among people from Aboriginal and Torres Strait Islander backgrounds, people from humanitarian backgrounds and people experiencing complex and multifactorial disadvantage.

Our region is characterised by extreme disadvantage existing alongside extreme advantage. Many people experience intersectional discrimination and marginalisation when trying to access the health, social and community services that they need, placing them at increased risk of poorer health outcomes. This is made worse by a "cost of living" crisis that has seen household expenditure on rent,

food and other essentials far outpace wage growth, combined with the lingering effects of the COVID-19 pandemic.

Mission statement:
Deep End Living Lab Frankston will work with policy makers, health service planners, clinicians and community members to overcome systemic inequities in health care delivery through evidence-based research for policy and practice change.

Our logo is based on the original Scottish Deep End logo, and includes the Deep End of a swimming pool, the steep slope of the health gradient in green and gold to represent Australia, the conch shell on a beach representing the Frankston and Mornington Peninsula region of Victoria.

Our work to date
Our team has been funded by the National Centre for Healthy Ageing to set up a "Living Lab" to study how frontline health services can better support people experiencing homelessness and unstable housing in the Frankston region.

We developed a "flag" for homelessness that can be used to identify patients experiencing homelessness or housing instability in large administrative datasets. The flag enables researchers and policy makers to measure health service usage, health outcomes and other key health metrics for people experiencing homelessness in a way that was not possible before this work.

We completed two qualitative studies to understand frontline health workers' perspectives on discussing housing during a health care consultation and consumers' experiences of accessing health services while facing homelessness or unstable housing. We are using the findings from these studies to improve how housing is discussed in health settings.

We are working with a public hospital network in the Frankston and Mornington Peninsula region to co-design a professional development activity to enhance frontline health workers' knowledge, skills and confidence to sensitively discuss housing issues with their patients, and, to offer supported referral to housing and other material aid services available in the local area.

We are creating a suite of resources for primary care teams (GPs, nurses, practice administrative staff) to more routinely discuss housing with patients. The suite will include waiting room resources to de-stigmatise housing issues, clinical practice guide on how to sensitively discuss housing and decision-aids to assist with identifying suitable services and referring patients to those services.

We convened a community forum which brought people with lived experience of homelessness and unstable housing together with the health and housing service sectors to identify shared priorities that could improve the health and wellbeing of people experiencing housing instability. We have produced and disseminated a short report to support organisations in working towards achieving these priorities.

To learn more about Deep End Living Lab Frankston or explore potential collaborations, please visit us at the Deep End Living Lab/Monash University or contact the team at liz.sturgiss@monash.edu or nilakshi.gunatillaka@monash.edu.

Our team: Elizabeth Sturgiss, Nilakshi Gunatillaka, Kimberley Norman, Lin Chai, Suzanne Nielsen, Helen Skouteris, Terrence Haines, David Blane, Taya Collyer, Philip Mendes, Claire Blewitt, Iain Edwards, Alice Urban.

POETRY COURSE

We loved producing and facilitating the workshops at the April Deep End International Conference in Glasgow and were keen to provide some additional opportunities for learning and connection using the arts and humanities.

Poetry seemed to be a particularly popular medium. Therefore, we (the Fair Health team) have commissioned a Poetry for Healthcare Professionals course, which will run in January and February 2025. The course will consist of six 2 hour online workshops to be held on Wednesday evenings. We have brought in an external facilitator / educator / poet + writer to deliver the sessions. There is a fee for the course to help cover the cost and support the work of the charity. We wanted to share details of the course in case this is something you would like to sign up for... for those of your who take part, it will hopefully be a nice way to pass some dark winter weekday evenings in the new year...

You can find out more about the course and enrol here: Writing poetry for healthcare professionals (fairhealth.org.uk)

Tom Ratcliffe

PREGNANT AND SQUINT

I had a holiday from awkwardness. *Can you have sex?* was solved. Most people have been or known a doubled self like us. Briefly my conditions were disabled.

Test to term I never had to console a passer-by spooked by my movement. People knew what to say. *When are you due? Do you know what you are having? Yes, a break.*

We were disconcertingly well. Nothing Abnormal Detected said midwive's scribbles. Just before childbirth, everyone's disabled. For me, same old, same old, I had cohabited with fatigue for years; my balance was dreadful; I already leaked.

Suddenly I had twice the rights on buses. I could be the belly, if I liked, or the girl balanced on a semi-circle. I qualified for both the reserved seats.

I liked the quaint but truthful phrase "with child".

The government forced me to list what I couldn't do. I had to excise you from my answers. Whilst I described the most disastrous days, the falls, the fits, the faff, the time I collapsed while trying to use a tampon, my oddly capable body made your kidneys.

Nuala Watt

This poem, possibly the only poem ever written about pregnancy and disability, was recorded by the BBC and can be accessed at https://www.youtube.com/watch?v=oq0eIAY2YT0

VISITING DEEP END PROJECTS IN ENGLAND, SCOTLAND AND IRELAND

Tim Senior

In the middle of 2024, I travelled halfway around the world courtesy of the Winston Churchill Trust of Australia to visit Deep End GPs in England, Ireland and Scotland. I work as a GP in Aboriginal and Torres Strait Islander health in Australia, and when I first came across the work of GPs at the Deep End in 2011, it seemed like they were describing my work.

Aboriginal people (from mainland Australia and Tasmania) and Torres Strait Islander people (from the islands near Papua New Guinea, off the tip of northeastern Australia) are the original inhabitants of the country we now call Australia. Their history on this continent goes back 60,000 years – compare that to, say, Christianity, Ancient Egypt, or the Chinese Dynasties - and Australia before European colonization was a continent of many Countries, with names unfamiliar to those outside Australia – Arrernte, Larrakia and Dharawal, to name three where I've worked.

The consequences of colonisation for Indigenous peoples of countries across the world are well recognized. We see similar themes and similar outcomes for Indigenous people in Australia, New Zealand, Canada, the United States and many other countries. Colonisation usually involves forced removals from homelands, forced removals of children from families, and massacres. This shows itself now in transgenerational traumas, and in transgenerational transfer of wealth.

This is why I had been so intrigued to read about the similarities in the work of Deep End GPs in Scotland and my own work in Australia. We had told ourselves in Australia that the health disparities seen in Aboriginal and Torres Strait Islander people were a consequence of being Aboriginal. What if many of the health consequences were related to poverty?

We see similar issues in rural and remote parts of Australia, where the sheer distances between major cities make it very difficult to get workforce and other services to geographically distant areas. When I worked in a rural Northern Territory town, locals had a saying: "Get ill, get on a plane." Clearly, that's only an option for those who can afford a plane ticket! The importance of geography and distance allows us to forget the importance of poverty for health.

Australia's health system is excellent, coming out third overall on the Commonwealth Fund survey of health systems. However, our health system really struggles where people can't afford to pay. The government health insurance

scheme, Medicare, has utterly failed to keep up with health care costs, meaning that health services ask an increasing number of patients for increasingly large co-payments just to keep the service open. The impact on my work is that our service (which doesn't charge co-payments) becomes increasingly underfunded for increasingly complex care. Non-GP specialists are increasingly difficult to access due to cost. I have it lucky, because these challenges are recognised for Aboriginal patients, and so there are some programs available that help access. For non-Indigenous patients who can't afford these costs there is nothing.

So, I came to the UK as a Churchill Fellow. My trip took me to the Society of Academic Primary Care conference in Bristol, where I met the Deep End Research Interest Group, and from there to meet Deep End GPs in Plymouth, across London, Dublin, Sheffield and Glasgow.

I had the unusual and very special opportunity to sit in with experienced GPs and watch them working with their patients. Time and again, I saw expert clinicians form trusting relationships with people who felt excluded by the health system, and were managing a complex mix of medical, psychological and social circumstances. I saw the face of a homeless person light up when she saw the GP she trusted on the hospital wards in Plymouth. I saw a GP joke with her patient in Dublin "I'm not your grandma! You're not in trouble!" I saw the dignity given to adults and children by finding them clothes in both Plymouth and Edinburgh. I saw the importance that creating gardens and natural spaces had for people, and I saw the importance of local knowledge about local housing and third sector agencies.

Everywhere I went, I saw systems that weren't working for patients. Secondary care could be unwelcoming, mental health services were often non-existent. I saw GPs advocating for their patients, and frequently finding ways of being quietly subversive in order to get the care that patients needed.

The way that GPs worked with their patients – in the words of Julian Tudor Hart "initially face to face, eventually side by side" - gave me a new appreciation of the model of service in which I work in Australia. Aboriginal Community Control is exactly what that says. My service, and about 150 others around Australia, are run along co-operative lines, and are owned and run by their local communities. This governance builds in community responsiveness for primary care, and as a result gets excellent outcomes for people whom the rest of the health system says are hard to reach.

I hope to bring back to Australia this appreciation of what we have in world-leading primary care in Aboriginal Community Control. I hope that the way Deep End practice connects personal, relationship based medical care with broader

connections to social agencies to act locally on social determinants of health, including social prescribing, can be brought more widely to Australia.

This work is hard, though, and every GP I met was carrying on in difficult circumstances because they were passionate about the rights of their patients to good health and good health care. I saw the support given by GPs and other primary care staff to their colleagues, educationally and socially. I'd like to enable this support to happen for Deep End GPs in Australia.

The work can be fulfilling, challenging and isolating. I've seen Deep End GPs at work with their patients, and, whatever else comes from my Fellowship, I can say I see you. Deep End GPs are there every day representing the best of our profession, and you are the embodiment of the motto of both the UK and Australian Colleges of General Practice:

Cum Scientia Caritas - "With knowledge, love."

Articles about my Churchill Fellowship

Bristol Conference: https://www.croakey.org/a-smorgasbord-of-treats-on-primary-care-and-related-research/
Plymouth: https://www.croakey.org/why-patients-need-health-professionals-who-are-dedicated-to-subverting-the-system/
Dublin: https://www.croakey.org/from-dublin-a-rare-and-inspiring-opportunity-to-observe-and-learn-from-general-practitioners-at-work/
Sheffield: https://www.croakey.org/an-emotional-return-to-sheffield-uncovers-important-insights-into-general-practice-and-communities/
London: https://www.croakey.org/postcard-from-london-on-why-primary-care-is-a-practice-of-place/
Glasgow: https://www.croakey.org/from-scotland-some-insights-from-general-practices-on-how-to-improve-care-for-communities-with-greatest-needs/

MY BABY BELONGS TO THE HEALTH BOARD

My baby belongs to the Health Board.
I feel like we've got her on loan.
And parents are here by permission
In this baby-processing zone.

They schedule perpetual visits
and set an intractable sum.
I am the square root of my baby.
I do have a name, besides Mum.

They draw me a breastfeeding table.
I don't know what that's all about:
headwords and columns and so on
Milk in and then excrement out.

I'm wrecked and depressed and exhausted
and motherhood is an exam.
I stare at the scales as my daughter
first gains and then loses a gram.

I'm only confused by these pamphlets.
"cause none of the diagrams match.
With what magic formula does one
Correct a sub-optimal latch?

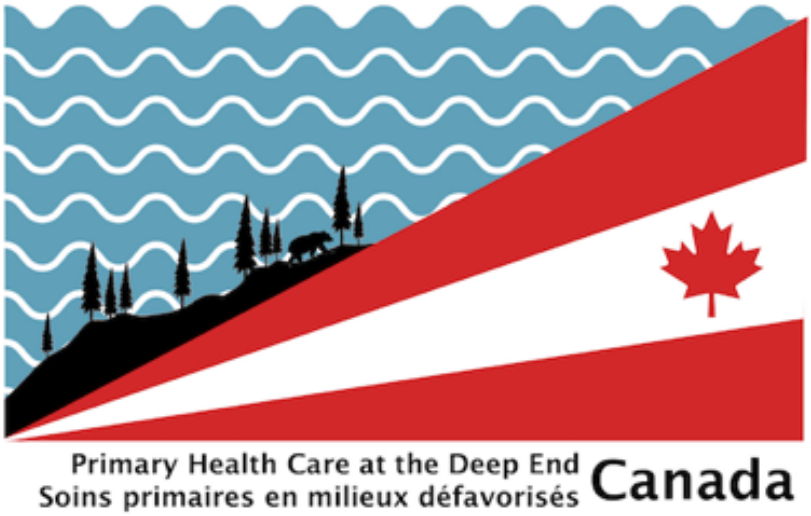
It might be a bit sore at first, dear
before it becomes a routine.
There's bruises on my areolae
What level of sore does she mean?

My baby belongs to the Health Board.
She fell off a centile today.
Forgive me my postnatal terror;
I'm worried they'll take her away.

Nuala Watt

This poem was included in *Mind Your Life : Poems for Nurses and Midwives*
Scottish Poetry Library/Polygon 2021

REPORTS FROM ESTABLISHED DEEP END PROJECTS



PRIMARY HEALTH CARE AT THE DEEP END CANADA

Joseph O'Rourke and Isabelle Fortuna
Upstream Lab, St Michael's Hospital, Unity Health Toronto

Primary Health Care at the Deep End Canada has had a busy start in 2024, since our first coalition meeting in June 26, 2024. We have grown to approximately 10 clinics and 5 patient partners in this short time, representing six provinces out of thirteen provinces and territories. Our current members include clinicians, researchers, and staff working in program evaluation and policy, health equity, and operations. They work in diverse primary care settings, including family health teams, hospitals, community health centres, community pharmacies, provincial health authorities, and research teams.

Why Deep End Canada?

Deep End Canada is a network of primary health care teams, including health professionals, researchers, patient partners, and decision-makers, working with patients who may face social and/or economic disadvantages. We advocate for addressing health inequities in primary health care at individual, organizational, and policy levels through the collection and use of social determinants of health data and the sharing of ideas and projects. Our network is guided by the following pillars:

1. Data-driven local solutions
2. Community and key actor engagement
3. Social action and advocacy

Currently coordinated by Upstream Lab, our goal is to ensure the sustainability of this network after the end of its current funding from the Canadian Institutes of Health Research and Canadian Primary Care Research Network. See the Deep End International Bulletin from June 2024 to learn more about our beginnings.

What have we done?

In September,

- We widely disseminated a survey about the Reach and Adoption of the SPARK Tool – a gold-standard 17 (plus two optional) item questionnaire on patient demographic and social needs ("social data") information for use in primary care. The Tool is available in English and French. We hope to learn more about if and how primary health care organizations are collecting these data and building the 'foundation' for advancing health equity within their clinical, organizational, and local settings.[1,2]
- We hosted our second quarterly coalition meeting to bring together primary health care teams across Canada and discuss ideas, challenges, and strategies for advancing health equity.
  - In light of National Day for Truth and Reconciliation on September 30, at this meeting we also reflected on the importance of Canadian medical professionals understanding harms committed against Indigenous people from "coast to coast to coast" – such as those for which the Canadian Medical Association recently apologized – when advancing truth and reconciliation initiatives within one's own settings and region.
- We engaged members through providing resources to support implementation of social data collection and individual coaching sessions to discuss topics such as Electronic Medical Record integration, interventions on the "use" of data, and previous approaches to collection of Indigenous data that respect Indigenous data sovereignty.
- We continued to build our website (https://deependcanada.org/) and uploaded over 25 resources to support clinics to implement social data collection.
- The SPARK Tool was included in the Canadian Centre for Health Information's 2024 Draft "Pan-Canadian Health Data Content Framework" to promote standardized collection of social data as a step towards local, regional, and national action on the social determinants of health.

In October,

- We celebrated the success of Dr Tiffany Lee, a pharmacist and Assistant Professor at Memorial University of Newfoundland, and Deep End Canada member based in Newfoundland who received competitive funding from the Canadian Foundation for

Pharmacy to continue advancing the work of health equity in primary health care, specifically to leverage the unique frontline position of community pharmacists to screen for social determinants of health.

- We disseminated the French version of the SPARK Tool, which was translated with the support of the Canadian Primary Care Research Network.
- We created a simple infographic for new members and to grow the network at various events. This will be disseminated at the upcoming North American Primary Care Research Group Annual Conference and the Canadian Primary Care Research Network Learning Cycle in November, 2024. The infographic is also available on our website and for members to distribute.

What are we working on right now?

- We are creating an internal portal within our website for members to access meeting minutes and share resources across the network, as well as a public-facing page to showcase our members and the work they are doing.
- We continue to meet with primary health care teams and networks across Canada to orient them to the network and identify opportunities for collaboration and support to advance health equity in primary health care.
- We continue to support existing members through facilitated coaching and providing resources.

What are our goals for 2025?

- We will continue to adapt our development evaluation of the network and its impact, seek opportunities to learn from Deep End Networks internationally, as well as seek funding opportunities to support central coordination of the network.
- We will identify opportunities to engage in member-led advocacy, such as advocating at policy levels for financial, logistical, and digital infrastructure support to collect and use social data.
- We will launch a follow-up survey regarding the Reach and Adoption of the SPARK Tool, to understand any changes in how organizations are collecting and using social data to address social determinants of health.

References

1. Adekoya I, Delahunty-Pike A, Howse D. et al. Screening for poverty and related social determinants to improve knowledge of and links to resources (SPARK): development and cognitive testing of a tool for primary care. BMC Prim Care. 2023;24(247). https://doi.org/10.1186/s12875-023-02173-8
2. Pinto & Block. Framework for building primary care capacity to address the social determinants of health. Can Fam Physician. 2017;63(11):e476-e482.

PRIMARY HEALTH CARE AT THE DEEP END CANADA

A primer for new members

Our Mission

Deep End Canada advocates for **addressing health inequities in primary health care** at individual, organizational, and policy levels through the collection and use of social determinants of health data and the sharing of ideas and projects.

Our Members

We are a network of primary health care teams, including **health professionals, researchers, patient partners, and decision-makers**, working with patients who may face **social** and/or **economic disadvantages.**

GUIDING PILLARS

Data-driven local solutions

Community and key actor engagement

Social action and advocacy

What you can expect

- **Materials and tools** for demographic and social needs data collection
- **One-on-one coaching meetings** to support clinic priorities and health equity initiatives
- **Facilitated meetings** to discuss challenges and strategies with other sites across Canada
- **Advocacy opportunities** for health equity in primary care and beyond

Deep End Canada is proud to be part of Deep End International. What started as a network of physicians serving the 100 most socio-economically deprived populations in Scotland, the Deep End Project now has coalitions around the world.

Primary Health Care at the Deep End
Soins primaires en milieux défavorisés Canada

FOR MORE INFORMATION

Visit deependcanada.org
Contact info@deependcanada.org

Version date: 16-Sep-2024

CANBERRA, AUSTRALIA

Deep End Canberra

Objectives

- Provide a supportive environment and networking opportunity for healthcare practitioners working in the Deep End
- Share educational opportunities for members, and in time, with the wider community
- Advocacy for marginalised populations to improve health access and outcomes
- Build links with academic researchers to improve the knowledge base around marginalised populations
- Evaluation of this Deep End group against our stated objectives

Top row : Tanya Robertson, Jess Tidemann, Bree Wyeth
Bottom row : Peter Tait, Melanie Dorrington, Joo-Inn Chew

2024 activities

- Mental Health Care reform – advocacy for reform proposals generated from our 2023 workshops continued, with Dr Peter Tait leading the charge. Meetings were held with politicians, health administrators, psychiatrists and community/consumer groups over this local election year. Deep End is looking at involvement/input into several MH Planning and Co-ordination committees going forward.
- Piloting of an ACT opioid prescribers' community of practice, including identifying prescribers able to mentor doctors in training.
- Exchange of information/advocacy regarded access for disadvantaged populations to services including cataract surgery and EEGs.
- Nomination of Allied Health pharmacy colleague for Award for services to Deep End populations.
- Improving communication within Deep End group with meeting invites and minutes via Google Docs/Calendar, and establishment of phone messaging group for rapid information exchange.

2024 Co-convenors: Dr Joo-Inn Chew, Dr Jess Tidemann

Contact: deependcanberra@gmail.com

DEEP END EAST OF ENGLAND

Deep End East of England continues to grow and build momentum, despite having no funding or paid time! However, we would love to hear from others across the wider network for ideas regarding increasing our resources, to ensure ongoing

sustainability – please do get in touch with Jessica & Emily. emily.clark2@nhs.net, Jessica.randall-carrick@nhs.net.

Some highlights from our A-CREW workstreams:

Advocacy: We are part of the 10-year health plan working group on "I can stay healthy and manage my health in a way that works for me." NHS 10 Year Health Plan working groups. We will continue to represent Deep End Practices at the LMC conference in November 2024.

Climate Change: Climate change & Environmental sustainability is the additional workstream that Deep End: EoE identified was missing from our Deep End predecessors – we copied WEAR acronym – but adapted it to A-CREW.
At our Deep End EoE September Symposium, Dr Rebecca Davis (GP and Climate Change Education Fellow, Cambridge Clinical School of Medicine) demonstrated why environmentally sustainable healthcare is vital for achieving health equity.

Some useful resources:

- Institute of Health Equity - Sustainable Health Equity: Achieving a Net Zero UK (UCL) report (instituteofhealthequity - sustainable-health-equity-achieving-a-net-zero-uk)
- The Public Case for a Green New Deal – Medact report (The public health case for a Green New Deal - Medact)
- Centre for Sustainable Healthcare – info, case studies and courses (https://sustainablehealthcare.org.uk
- Delivering a Net Zero NHS – Greener NHS England report (Greener NHS » Delivering a net zero NHS (england.nhs.uk))
- Lancet Countdown annual report Countdown health climate.
- E-Learning for Health - has 3x 30minute modules (New Environmentally Sustainable Healthcare elearning is available - elearning for healthcare (e-lfh.org.uk))
- Sustainability Leadership for Greener Health and Care Programme – (Free 21 week course) (NHS Leadership Academy - Leading for Sustainable Health & Care programme
- UK Health Alliance on Climate Change – raise awareness and influence change (UK Health Alliance on Climate Change)
- GIFH Toolkit - an audit tool that also provides sustainability awards for primary care. Has lots of ideas and ready-made resources (Green Impact.org.uk)

- We note that the World Health Organization WHO demands urgent integration of health in climate negotiations ahead of COP29.

Research and Education: We have taught across various GP Training Schemes, Universities and through Training Hubs this year. At our September Symposium we also heard about the Sanctuary Ambassadors project in Norwich as part of the City of Sanctuary health stream. Their primary mission is to embed the voice of those with lived experience of seeking asylum into healthcare education, research and system design, ensuring that their voices are heard and valued. The ambassadors were involved in a research dissemination events in Refugee Week Norwich 2024 called "I will heal" and have taught nearly 500 undergraduate students across UEA and Cambridge Medical School. Sanctuary Ambassadors Project

The Sanctuary Ambassadors team at the Lord Mayor's procession in Norwich, July 2024 with the City of Sanctuary Health Stream leads Dr Emily Clark and Dr Hannah Fox.

Workforce and Wellbeing: With burnout and staff turnover continuing to rise at alarming rates in the NHS, this white paper from the Institute of Healthcare

Improvement reminds us of four steps leaders can take to improve joy in work and a framework with nine critical components for ensuring a joyful, engaged workforce; key change ideas; and measurement and assessment tool. IHI Framework for Improving Joy in work

Emily Clark and Jessica Randall-Carrick

GPs at the Deep End, Ireland

Dr Brid Shanahan, Clinical Lead for Deep End Ireland contributed to a panel discussion at the RCSI/ICGP GP retention symposium in the Dublin Convention Centre on the 24th of September 2024. The following issues were raised.

Patients living in areas of deprivation tend to experience significantly higher morbidity and mortality rates when compared on issues like drug use, unhealthy health behaviours or suicide; however, this perspective overlooks the complexities involved. In reality, patients in Deep End practices frequently develop illnesses such as cancer and chronic disease in their 50s and 60s - conditions that would typically not pose serious threats to other individuals until they reach their 70s or even 80s. This results in an increased workload for Deep End GPs compared to our peers. This is especially inequitable considering that many health systems have increased capitation payment rates based on age, but many of our patients do not live into older age.

Another significant challenge in Deep End practices is that interpreters are required for a significantly greater number of consultations, and these consultations typically take at least twice as long as those where both the GP and the patient speak English. This places additional pressures on practitioners and is often not resourced adequately. There are also higher rates of homelessness in these underserved areas, which complicates the situation even further. Managing the care of homeless individuals within general practice settings presents significant logistical challenges for multiple reasons, including their frequent changes of address and phone

numbers, the difficulties these patients can face in attending scheduled appointments, and the lack of stable housing, which can exacerbate their ongoing health issues and make it even more challenging to manage their illnesses effectively.

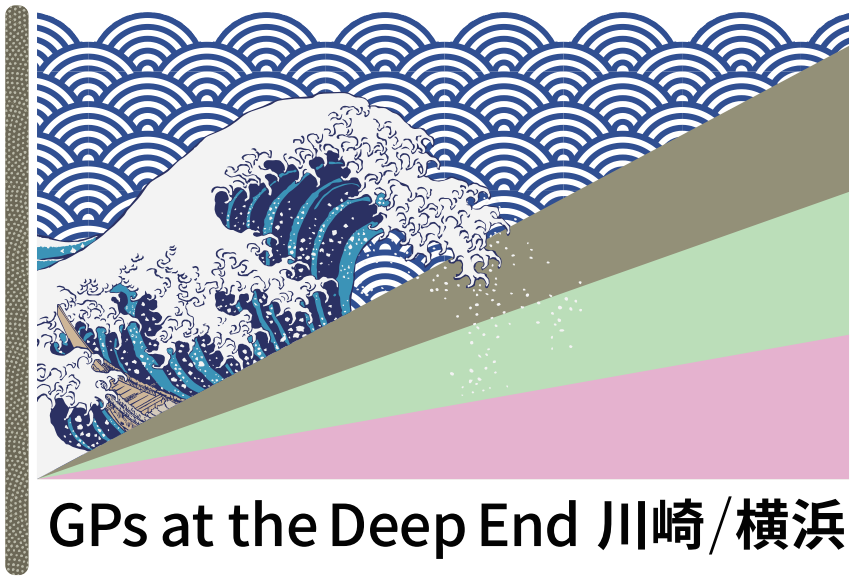
The Chronic Disease Management (CDM) programme in Ireland involves an additional payment to practices for two consultations a year in relation to certain chronic diseases. While CDM can contribute to a more equal distribution of resources, as there are more patients with chronic conditions in Deep End practices, the programme provides equality, not equity. An equitably resourced chronic disease management programme would involve allocating additional resources specifically to those who are most in need.

We need more GPs working in the existing practices in areas of deprivation, but we also need more GPs to set up practices in these areas. The current GP contract in Ireland is a major disincentive to doing this. The contract is based on a capitation model that assumes that all practices have comparable levels of need, which does not hold true for Deep End practices. We are tasked with delivering the same standard of care to a much more complex patient population, yet we do so with fewer resources.

Working in the Deep End, although very fulfilling, can be emotionally draining. Many Deep End GPs aim to provide trauma-informed care which can mean doing things like providing same day appointments for many patients who otherwise would not return. This results in many extra appointments every day. Ideally, there would be enough resources to provide patients living with additional challenges with longer appointment times instead of squeezing them in to fully booked clinics. We need to consider how we can support GPs and their practice teams to prevent staff burn out.

Addressing health inequity by providing additional resources would help attract more GPs to work in areas of deprivation thus increasing doctor patient ratios in those areas, allowing longer appointment times when necessary, improving working conditions and job satisfaction for Deep End GPs and ultimately improving health outcomes for patients living in areas of deprivation. This would ensure the viability of general practice in areas of deprivation across the country for years to come.

KAWASAKI AND YOKOHAMA, JAPAN



A new website “Kanagawa Good Primary Care”
As a part of the Deep End Kawasaki/Yokohama Project, we launched a new website “Kanagawa Good Primary Care”. (Figure 1 below is the top page of the website.) Kanagawa Prefecture is located next to Tokyo and includes Kawasaki City and Yokohama City.

The website aims to introduce social good projects in the prefecture. For example, we shared experiences such as a collaboration between a clinic in a deprived area and a university in Yokohama or a regular case conference focused on complex or chaotic cases in the primary care setting.

The website sets out seven important themes: social determinants of health, social deprivation, fragmentation of care, abuse, geriatric emergency medicine, sexual health and migration health.

Now, five clinics and two hospitals have shared their ”Good Practice” on the site. They tackled different problems in each setting. However, sharing activities on the same platform may empower colleagues in other areas and we can share our tacit knowledge. The platform will promote collaboration among GPs addressing similar social problems in the same prefecture.

Figure 1. Top page of Kanagawa Good Primary Care

Kanagawa Good Primary Care: https://pcru-kanekolab.studio.site/kgpc

LONDON

London Deep End Health Equity

Our online community continues to grow and stands at 305 members. The space is inclusive and has a diverse membership. The only eligibility criteria being that you care about Deep End and Health Equity, are willing to introduce yourself and share what you care about. This is to enhance a sense of belonging.

The main tenets of the group are that it is a trauma-informed, safe, virtual space and is collectively managed with distribution of responsibility to all. The language in the content has a foundation of mutual respect and warmth.

It continues to be a self-governing, non-hierarchical, informal network. Ideas, events and activities are shared, and connections are made to augment work and create new collaborations.

It is also a place where you feel a sense of belonging, solidarity and interconnectedness with like-minded people with similar values.

"It helps to read on a daily basis the thoughts of so many caring human beings, keeps me energised and I share the link with others so hopefully educating many more"

Elizabeth Oddono (Volunteer Community Hub)

The group has a diverse membership including but not limited to pharmacists, social prescribers, public health, GPs, hospital doctors, specialty doctors, ICB colleagues, system leads, trainees, students, nurses, allied health care professionals, personalisation roles, training hub colleagues and voluntary sector colleagues.

Our group and how we formed was shared in a recent BJGP article if you want to find out more
https://bjgplife.com/creating-a-deep-end-virtual-community-for-health-equity-in-london-collaboration-through-connection/

Some vignettes of the work of our members:

(1) *"I am education lead for the NHS England 'Enhancing Generalist Skills' (Enhance) programme in London and its curricular domains allow a way into conversations about complexity and justice (which we try to do within our four-day 'Thinking Together' programme-see images below). Creating a fairer, more equal society where everyone has access to opportunity is clearly a more sustainable approach to addressing unemployment than is medication. As clinicians, not all of us will be able to influence macro-level government policy, but we have choices on a more micro level – how we respond to and engage with patients, whether we offer relational continuity and whether we use our contextual knowledge to advocate for people. Cultural change that will enable this approach to health is desperately needed – whether for individuals, for populations or for our planet – and it is this that underpins the enhance work in London."* **Dr Rupal Shah**

For more information see Enhancing Generalist Skills | NHS England | Workforce, training and education website.

Deep End Book Club

An off shoot of the Deep End London group has been the online book club, made up of approximately thirty members. Since July 2023, the book club has met every 2-3 months and discussed a mixture of commentary, biographical and fictional publications, including :-

- Why We Revolt by Victor Montori
- A Fortunate Woman by Polly Moreland
- Fighting for the Soul of General Practice by Jens Foell and Rupal Shah
- My Friends by Hisham Matar

On more than one occasion, and more unusual for book clubs, the author of the publication has either joined for part of the meet-up or sent a message through to be shared. The book club has provided another informal space, alongside the

WhatsApp group, to share thoughts around health equity and justice topics that the various books have inspired.

From one member:
"Such a supportive group. Lovely to feel connected. Book club provides stimulating ideas and critical thinking. Helps to get into others' shoes and increase curiosity within clinical consultations".

DEEP END OUTER NORTH-WEST LONDON

The population and health systems in outer NWL has characteristics such as a large number of single-handed practices, a multitude of languages, and communities with rich histories that combine to make a unique landscape in the capital. RCGP NWL Faculty have funded educational and networking events to address needs that members have been unable to access elsewhere.

The Faculty was approached by Dr Nick Kates from McMaster University in Ontario, Canada, as they are creating a multidisciplinary primary care clinic in a deprived part of Hamilton. Dr Jo Thorne and I hosted Dr Kates, where we shared examples of practice, connections, and discussed challenges and solutions. We also hosted seminars with over 60 registrations per session, for example on using artificial intelligence to support evidence-based healthcare commissioning, and on refugee and asylum seeker health.

Here are updates from two of our members- firstly, **Dr Amisha Babl**a who co-founded this group:

Of the many challenging aspects of working at the Deep End, often it is the feeling of powerlessness to make the changes to the systems repeatedly failing my patients which I find most frustrating. Meeting other GPs working creatively to reduce health inequalities has been inspirational, and through them, I have recognised that my intimate understanding of the systems and barriers and the health impacts of these, is a strength and a resource in itself. Using this experience to lend a voice to support the organisations and work needed to create change has been empowering and has transformed how I view the aims and outcomes of my day-to day work.

I have spoken about the support needed for those experiencing homelessness as they are discharged from hospitals at a meeting of the All Party Parliamentary Group for Ending Homelessness; about the difference specialist services for people experiencing homelessness can make at NHS Confed Expo; and I have become a

trustee for Advice for Renters, a charity lobbying to improve housing conditions for private tenants.

Even if these moments of speaking up don't directly result in any change or action, I take comfort in knowing that the stories of my patients, the challenges and possible solutions have all been shared with those who have the power to make things better, and I hope that a seed has been planted in their thoughts for the future.

Secondly, here is an update from **Dr Sharon Raymond**, GP and director of Crisis Rescue Foundation.

The Crisis Rescue Foundation has been delivering Vaxi Taxi Health and Wellbeing Pop Ups in areas of deprivation across London since early 2021. We have delivered about 60 Vaxi Taxi Pop Ups so far, with backing from the NHS, local councils, the Mayor's Violence Reduction Unit, and private healthcare. We focus on communities experiencing deprivation and barriers to accessing NHS care, including refugees, asylum seekers, the homeless, sex workers, and people accessing foodbanks and other community based support services, and Vaxi Taxi Pop Ups are delivered in a wide range of settings, such as homeless shelters, refugee centres, drug and alcohol rehabilitation centres, colleges, football and boxing clubs, faith centres, as well as community festivals and more. We offer health checks, including mental health, blood pressure, BMI, and information and signposting on disease prevention, including vaccination, early detection and care of a range of common and significant health conditions and issues, such as cancer, diabetes, hypertension, mental health and wellbeing.

The Vaxi Taxi team offers individualised health and wellbeing information, and provides free toiletry goodie bags, food and clothes. We work closely with local services and community groups to deliver a bespoke offer that serves the needs of the community we are delivering the pop up for. Outcomes and feedback from service users has been overwhelmingly positive. Our work has been highlighted by the NHS Strategy Unit, at Downing Street, by the Vaccines minister, shortlisted for the HSJ Community Care Initiative of the Year Award 2023, and research on the pop ups was published in the British Journal of General Practice earlier this year (https://bjgp.org/content/74/suppl_1/bjgp24X737937).

Please see our website for more information on the Vaxi Taxi Pop Ups https://www.crisisrescuefoundation.co.uk/vaxi-taxi-health-and-wellbeing-popup. If you live or work in outer NWL and want to connect with our group, please contact

Camille mcgajria@gmail.com.

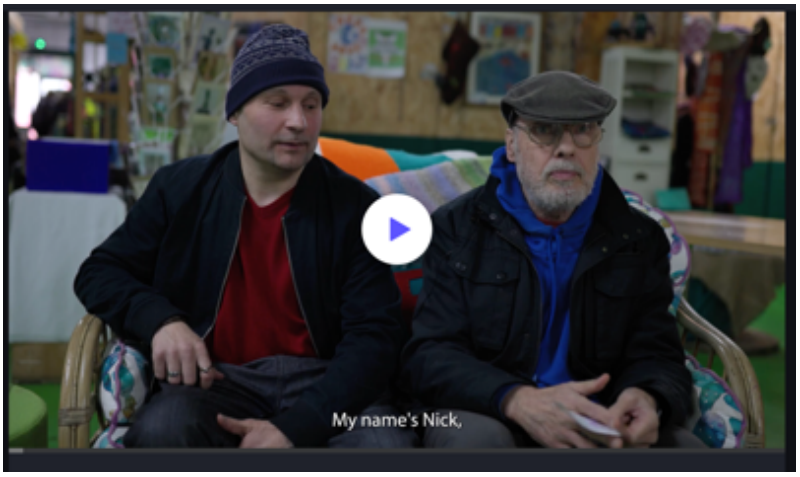
PLYMOUTH DEEP END

The aims of our Deep End Project, now 3 years old ,were to attract new doctors to work with us in our busy and mostly struggling practices, to educate doctors, students and others about everything to do with health inequalities, to be advocates for our patients and our community and to participate in useful research that makes a difference.

We have struggled to get funding from Devon NHS for our Deep End work, so everything is voluntary and we lack a web or social media presence, something that we are beginning to correct.

However, we have obtained project grants via the Health Inequalities Fund and have used those this year to further our aims.

Firstly, we have run community outreach days, linking up with a range of health and wellbeing services to proactively go out as a roadshow into the most needy parts of our communities. We call these “Feel Good Fridays” and they have been a great success. Videos are here https://app.frame.io/reviews/1bf0ffc4-ca58-4a9e-b86b-d0a739c24170/b8a339d7-3bba-4b34-bf69-919387999c62

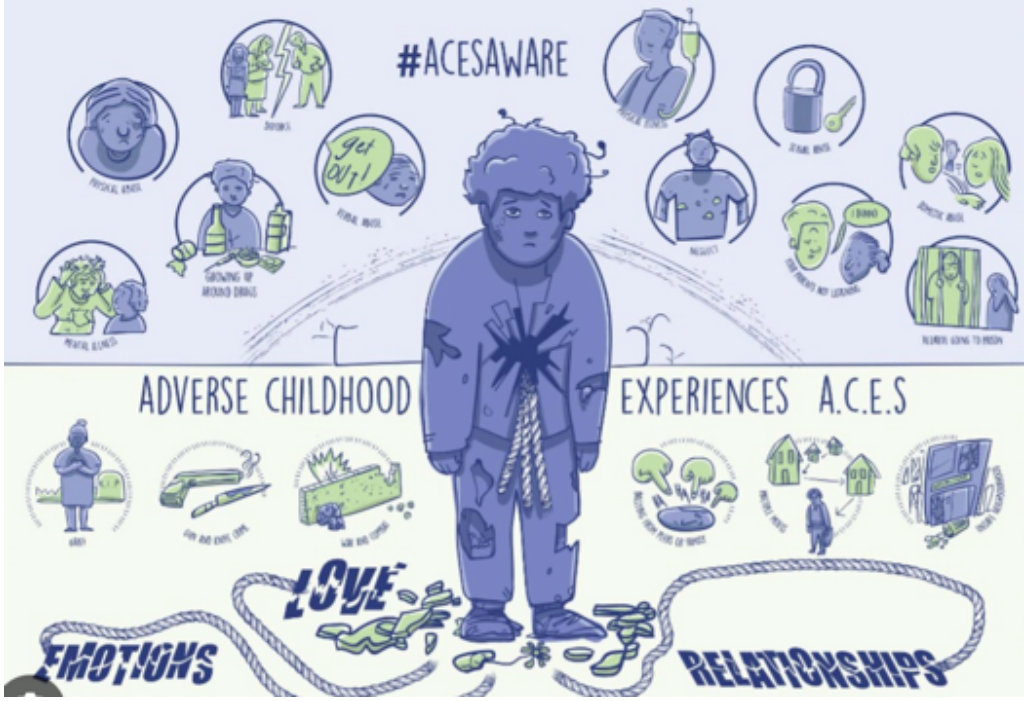


The next project has been the employment of 4 community health workers (Or CHWWs as we call them). This is based on work originally done in Brazil and then adapted first in London and then In Cornwall. All 4 are local people, working between the practices and the community. What they do is summed up in the graphic.

It is early days of this project, and we are still evaluating it – but evidence from Brazil and London suggests improvements in care particularly of long-term conditions as well as reduction in GP visits and emergency presentations.

The third project is running trauma-informed clinics. This is led by Elpitha Bruce, one of our GPs who has trained and specialised in trauma-informed practice and takes referrals from Deep End practices of patients presenting with complex physical and mental health symptoms. We run these in a neutral space outside the practices.

We all know that so much of what presents to us as GPs has its roots in past or indeed present trauma and adversity. We are hoping that these additional clinics will help with some of our most needy patients



Elpitha herself was attracted to us in Plymouth via one of our Deep End Fellowship schemes, and these are still running - now also more widely across Devon as Heath Inequalities Fellowships. They continue to attract a diverse range of doctors to come and work with us.

We also have a lot of medical students from our local medical school. We run the only clinical week that is set in the community (on substance misuse and complex needs) so all students coming to Plymouth pass through the practice and our outreach and in reach services. We also run a special study unit on Deep End practice and currently have 7 students working with us.

A major part of our work now is finding a new space for 2 of our most needy practices who currently work in terrible buildings. The last government promised us much and, in the end, delivered nothing. However good has come from the work that we did in preparation - and we are now designing what we are calling a “health and wellbeing village” situated in the centre of our highest deprivation community of Stonehouse. This will be a collaborative venture between us and community groups with whom we work closely. In contrast to the previous government project, this will be low tech, based on using local and recycled materials and using local labour and talent to build it. We have had high profile support from our Devon NHS, from the

city council and MPs, but all claim to have no money to pay for even our modest proposals. So, we are going down a crowdfunding route. Watch this space!

Finally, research in which we were involved (called the PL1 project) looking at negative experiences of homeless and complex needs patients at the interface between our local hospital at Derriford and the community continues to drive change. This includes releasing funding for our new in – reach service, based on the Pathway model in London which has really changed care for some of our most marginalised patients.

We are hoping soon to continue work we started looking at digital exclusion – and to relate it to the "missingness" agenda that has been so elegantly discussed by Deep End colleague Andrea Williamson and others in Glasgow. We know that many people, especially in the BAME community and those experiencing homelessness are often excluded by the various triage systems that we are all introducing in response to impossible workloads. We will be looking to find workable solutions.

It's so exciting to see our International Deep End movement grow and spread around the world. We very much look forward to the next newsletter and our thanks as ever to Graham for all his work in getting all the exciting work of Deep End practices collated and out there.

Dr Richard Ayres. Lead GP, Plymouth Deep End

THE DISABLED

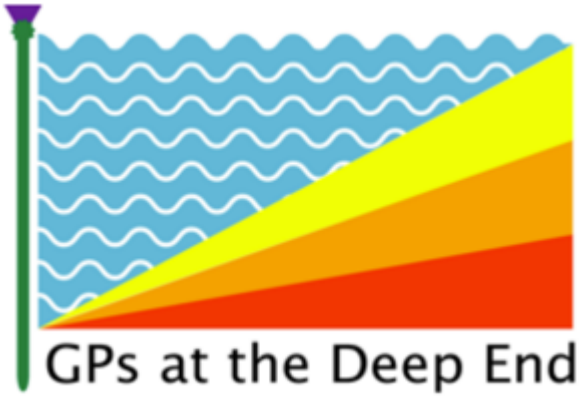
As if

we could

all occupy

one phrase.

Nuala Watt



SCOTTISH DEEP END PROJECT

Reflecting on the work of the Scottish Deep End project over the past year, three feelings come up: gratitude, connection and pride. It's been a busy, but important, year and working with Deep End colleagues often feels like a ray of hope in otherwise dark times.

It was our 15th birthday this year, and the best gift we could hope for was to celebrate it with Deep End friends from across the UK and beyond, at our international conference on 'Wellbeing at the Margins' held in Glasgow in April. Over two days, covering themes of Joy, Advocacy, Inclusivity, Kindness and Hope, we heard from speakers who inspired and challenged us, attended workshops and walking tours, and danced the night away.

We were extremely fortunate to have Ed Sharp-Paul attending the conference, who volunteered to capture the key elements for us…and this he did, in a fantastic 9-minute video that can be viewed here. The full talks can also be viewed here.

Roundtable meetings

We've been busy hosting roundtable discussions too, bringing people together for conversations on important topics, capturing the themes and our recommendations in Deep End reports which we then use for wider engagement and influencing.

In March, we co-hosted a hybrid roundtable meeting with Emergency Medicine colleagues, Jo Quinn and Ryan Hendry, the driving forces behind the newly created Emergency Medicine at the Deep End (See Page11). The aim was to share learning on how best to design and deliver services, and support patients and workforces, recognising that in emergency care, social deprivation often drives people to attend, colours their experience, and affects their outcomes.

The report (Deep End report 41) will be hosted on the Deep End website soon, with further info on the EM at the Deep End website.

In June, we held a roundtable to discuss Continuity of Care in the Deep End. Following a brief presentation from Carey on the evidence base, measures of continuity, current challenges and potential 'levers' in the system, a productive and wide-ranging discussion followed (including noting with envy the 7 "core values" of Nordic family medicine, with continuity of care as a central organising principle). Thanks to Peter Cawston for facilitating the discussion and writing the report, which will be online as Deep End report 42 very soon.

In October, we met in-person as a steering group. We welcomed new and younger colleagues and took the opportunity to reflect on where we are and where we want to be. Discussion included consideration of widening membership, input of people with lived and living experience, and collaborative working with RCGPS, BMA and others. Planned roundtables include "Language and Cultural health inequalities" (December) and "Mental health support for children and young people in the Deep End" (early 2025).

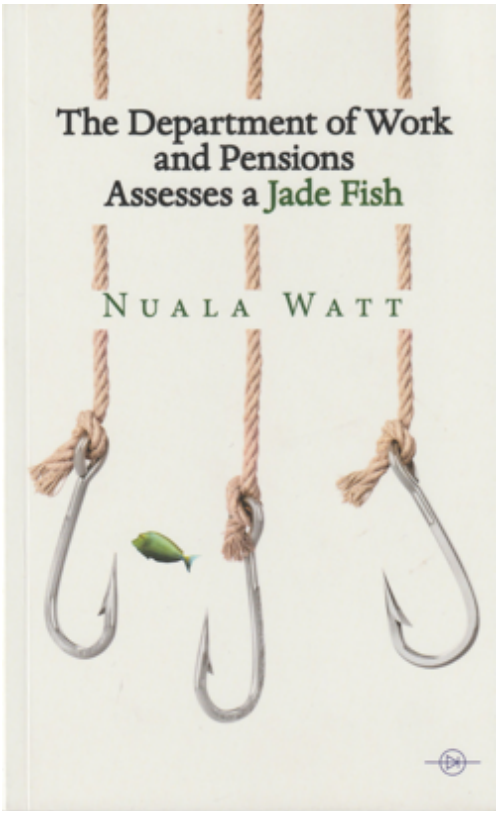
Scottish Deep End steering group meeting, October 2024.

Ongoing projects and policy involvement

- Ongoing learning from established roles (Community Links Workers and Welfare Advice and Health Partnerships).
- Early evaluation of new initiatives (Inclusion Health Action in General Practice and Family Wellbeing Support Workers, part of the Scottish Government's Whole Family Wellbeing Fund).
- Advocacy related to addressing the Inverse Care Law, 'missingness', and the need for Proportionate Universalism, cited in the most recent CMO report!

We would like to thank everyone in the DE Steering Group for their ongoing support.

Carey Lunan and David Blane



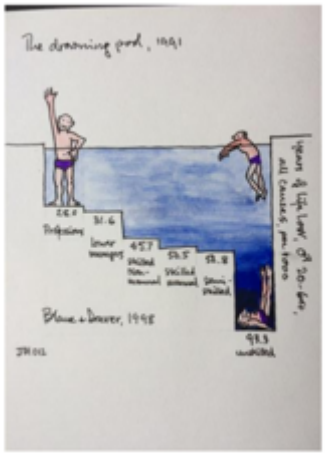
Nuala Watt's poetry collection *The Department of Work and Pensions Assesses a Jade Fish* is available from Blue Diode Press www.bluediode.co.uk

Meddygon Teulu yn y Pen Dwfn
GPs at the Deep End

DEEP END CYMRU

The Deep End Cymru vision is for NHS general practice to be at its best where it is needed most

Deep End Cymru is a grassroots movement inspired by Julian Tudor Hart, a GP here in Wales. It is about developing mutual support and using this over time to generate change to improve healthcare services and health outcomes for people with the greatest health needs. It is a way to bring a stronger health equity lens to all business as usual, for example in Cluster plans and Social Prescribing programmes. It aims to add value for those communities who are often less able to access and benefit from existing services.



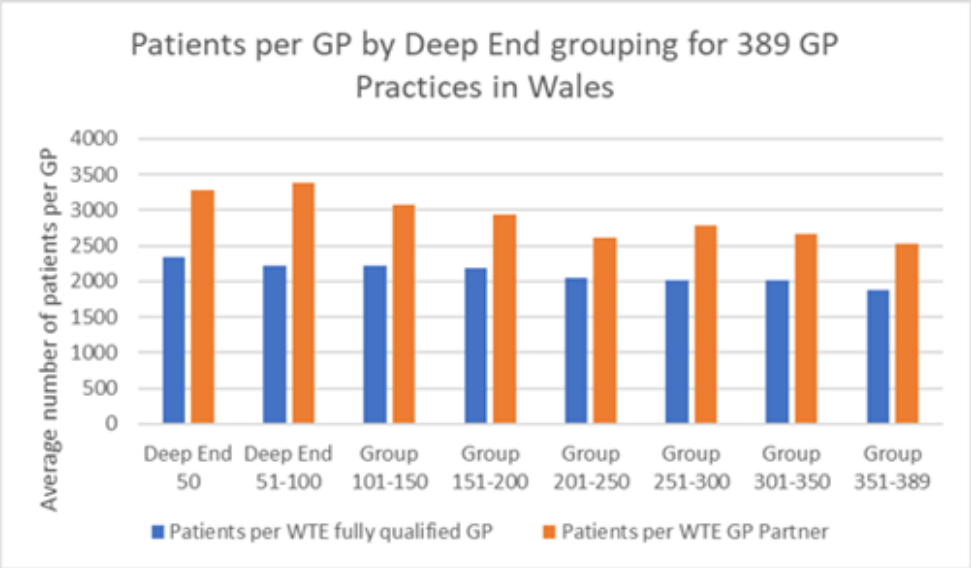
Deep End practices: Wales had 389 practices when we started. We invited the 100 GP practices that had the highest proportion of their patients living in the most deprived 20% of communities in Wales. The proportion of registered patients living in these areas ranged from 48% to 83% in the top 50 practices and was greater than 34% for all the Deep End practices. These were predominantly located in Southeast Wales, in four of the seven health boards. However, they are not concentrated in Clusters with very few Clusters having a majority of Deep End practices. Deep End practices reach almost 60% of the 653,413 people living in the most derived quintile in Wales. Of the 100 practices invited, seven had already closed or merged. Of the remaining 93, 85% responded with 35% attending at least one Deep End event in person.

- Deep End practices are closing or merging at double the rate of other practices
- Deep End practices are drowning faster than average
- Deep End practices have a greater workload and a smaller workforce.
- GP partners in the Deep End have on average 764 (29.7%) more patients than those in the 100 least Deep End practices.

Deep End findings: Participants were concerned that patients faced too many barriers to accessing the best quality care (such as not having English as a first language, being insecurely housed and having lower health literacy skills). Their ability to provide high quality was affected by excess workload, and a lack of adequate workforce. Five half day events were held over 18 months, including the launch in November 2022. Our common challenges were identified, and the prioritised, and we then did deep dives into these.

We moved quickly from describing problems to coming up with potential solutions. These were multiple, varied and innovative, with staff sharing what they were doing and learning from each other. Much of the focus was about non-medical solutions for patients, such as social prescribing, in particular support for income maximisation and housing, and for those with complex needs.

Many felt that becoming a training practice was the best route to recruitment, but that current GP Training schemes did not take account of the value of Deep End experience, or match interested Registrars to Deep End practices. Many felt that losing their skilled and experienced staff was a constant threat and would be improved through measures to improve income and morale.



The top four priorities that we wished to work on emerged as:

1. Finance and funding
2. Workload
3. Recruitment and retention

4. Education and training

Feedback

- The project was met with enthusiasm by participants.
- Participants say they love to work in their practices, and expressed a strong wish to be able to do more and do better

Solutions

The key message from the experience so far is:

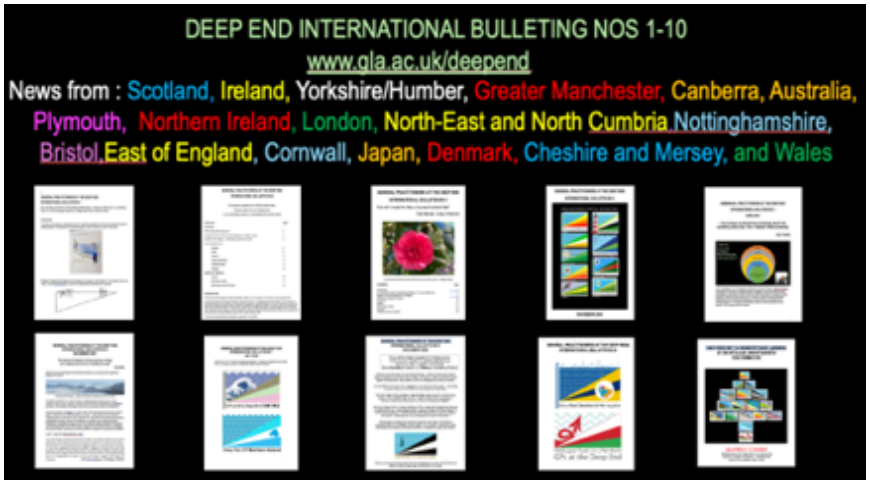
1. **Capacity.** We develop at the speed of trust, and this takes time, energy and capacity to build.
2. **Protected time**: Deep End staff have a greater workload, so gaining some time and headspace for improvement work through Deep End will only happen if their time out is genuinely protected with full cover for their normal workload.
3. **Workforce.** Our participants say they love working in their practices, and many GPs in training are very keen to have placements with them but we believe that this is not promoted enough. We have begun work with stakeholders to promote multi-disciplinary training of health workers to work in more deprived areas and in health inclusion. We have influenced GP training, by facilitating four Vocational Training Schemes in South Wales to reserve one place each for specialising in deprivation medicine.
4. **Non-medical needs**. We considered how best to meet the non-medical needs of our patients, and how to connect them with community assets, so are now developing a proposal for community health workers
5. **Research**. We have engaged with the research community, here in Wales and through the UK Deep End Research Network. We have already built a strong relationship with the Division of Population Medicine at Cardiff University as our “academic home”. We want to answer the questions most relevant to our patients, and also to get more practices and patients engaged in research. We are about to publish our first research study.
6. **Education**. We are keen to share learning about what works, and have run a series of online “lunch and learn” sessions and a very successful Health Inequalities Study Day, planned to be an annual event.

7. **Staff Well Being**. We are very aware of the stress that all General Practice is under and know that our teams are at the sharpest end of this. We know that the mutual support we already have is valued, and we want to formalise this to improve staff wellbeing.
8. **Resource allocation**. We have identified inequalities in workforce and funding that have not been identified elsewhere and are not being addressed. We know that Deep End practices are more likely to close, merge or be taken over by external companies. We have a role in advocacy for practices that have the least time to do this for themselves and are at greatest risk of folding, leaving their patients at an even greater disadvantage.

Conclusion

The purpose of the first phase of Deep End Wales, was to conclude whether a long-term Deep End programme is feasible, acceptable and likely to add value to patients and staff in Deep End practices serving the most deprived communities in Wales.

We believe that we have demonstrated this, and that Deep End is here to stay.



Deep End International Bulletins 1-11can be accessed at https://www.gla.ac.uk/schools/healthwellbeing/research/generalpractice/deepend/international/

DEEP END YORKSHIRE AND HUMBER

'No Health Equity without Research Equity'

We founded DERA (Deep End Research Alliance Yorkshire Humber) in 2016 - a tripartite collaboration of patients and communities; frontline practitioners in a clinical research network (DE CRN), and a local primary care department, to co-create useful, relevant and inclusive research This year DERA has gone from strength to strength pushing the boundaries of inclusive research methodologies.

We continue to attract funding to DE research: NIHR fellowships (Advanced x1, Clinical lectureship x3; ACF x4); project grants (RCGP, NIHR HTA, Yorkshire Cancer Research) and NIHR RDN support for the DERA core research and administrative team to catalyse inclusive research and community engagement through DE research symposia and a community research link worker (CRLW) programme.

The CRLW programme demonstrates our commitment to building grassroots research capacity in underserved communities, with a wider aim of addressing exclusive power and skewed positionality-driven agendas in academic institutions, recognising also the impact of cultural trauma on minoritised communities DERA - Community Research Link Worker (1,2)

DERA supports and innovates in inclusive-research-by-design with several university partners (Sheffield, Leeds, Keele, Oxford, Bristol, Newcastle) and supports intervention development and delivery of larger external studies within the DE NIHR funded Sheffield Clinical Research network and a new Deep End CRN in

Leeds. DERA has also, through individual mentorship, supported the wider adoption of DERA approaches to bring together multiple sources of funding and integrate research delivery with engaged practitioner, patients and academic partnerships to reverse the trend towards non-representative research which selectively excludes Deep End patients and generates evidence-biased medicine.

Some changes:
Kate Fryer now leads DERA YH since **Caroline Mitchell** became Professor at Keele UnIversity but CM remains a DE sessional DE clinician undertaking collaborative research within DERA. CM also chairs NIHR supported online meetings of a national network of > 10 DE-badged and NIHR funded CRNs.

In January, our first national NIHR supported event will bring together DE stakeholders, patients and communities from across the English RDN to a launch webinar where we will share experiences and learning about widening participation in research by DE patients and DE practices, making UK research more representative, inclusive and useful in primary care at the DE.

Please see these web links for exciting work being led by our DERA rising stars in:

- Lung Health Shamanthi Jayasooriya- NIHR Advanced Fellow: DERA - Lung Health;
- Josie Reynolds ACF - culminating in a transformative community-led 5-day 'photovoice research' exhibition :DERA - Exhibition ;
- Reproductive Health: Becky Mawson NIHR ACL DERA - Reproductive Health ;
- Bone health of Men with Prostate Cancer : Qizhi Huang NIHR ACL DERA - Prostate cancer

References

1. Fryer, K., Hutt, I., Aminu, H. et al. Contextualising and challenging under-representation in research in light of Cultural Trauma: a qualitative focus group and interview study. Res Involv Engagem 10, 69 (2024). https://doi.org/10.1186/s40900-024-00600-3

2. Mitchell C, Fryer K, Guess N, Aminu H, Jackson B, Gordon A, Reynolds J, Huang Q, Jayasooriya S, Mawson R, Lawy T. Underserved 'Deep End' populations: a critical analysis addressing the power imbalance in research. British Journal of General Practice. 2023 Jul 1;73(732):326-9. https://doi.org/10.3399/bjgp23X733461 https://doi.org/10.3399/bjgp23X733461

IMPORTANT INFORMATION ENCLOSED

We're ready to help get your bills down.
We're ready to break down your door.
And gift you a pre-payment meter
to stop you from shivering more.

Perhaps you did not learn to budget,
But we can assist you with that.
And can we suggest, in the meantime,
You stay on one room in your flat?

We see you've restarted your asthma.
There's not enough gas for a bath.
You cough when you go to the bathroom.
A more parsimoniious path

Could help you to quash all these problems.
And follow our energy plan.
We do understand, and we promise
To help you as much as we can.

Perhaps you could turn down your boiler.
Is your jacket too thin? Buy a spare.
The weather created this crisis.
We want you to know that we care

Nuala Watt

This poem was included in the Poetry Archive after a competition for poems reflecting difficult times during Covid and afterwards
https://poetryarchive.org/poem/poetry-archive-now-wordview-2023-important-information-enclosed/

The Poetry Archive is the only charity wholly dedicated to the production, acquisition and preservation of recordings of significant poets reading their work aloud.